MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01444

CERTIFICATE OF DEATH

1463

Reg. Dist. No. 26

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Finksburg Rural
LENGTH OF STAY (in this place) 20 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Finksburg - Rural
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) GARAFIELA (Middle) - (Last) ABBOTT

4. DATE OF DEATH: (Month) Feb (Day) 15 (Year) 1955

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widow

8. DATE OF BIRTH: Dec 28-1879

9. AGE last birthday: 75 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jesse Hare

14. MOTHER'S MAIDEN NAME: Eliza McComas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Mr Kenneth Abbott, Finksburg Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.1

Immediate cause (a) Myocarditis (chr)

DUE TO Coronary Embolism

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) arteriosclerosis

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1945, to Feb 15, 1955, that I last saw the deceased alive on Feb 15, 1955, and that death occurred at 10:10 P.M., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) W. C. Jesmith MD ADDRESS 103 E Main Westminster Md DATE SIGNED 2-16-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF Feb 19/55

NAME OF CEMETERY OR CREMATORY Emory

LOCATION (City, town, or county) (State) Carroll Co Md

DATE REC'D BY LOCAL REG. 2-18-55

REGISTRAR'S SIGNATURE Hazel Miller

24. FUNERAL DIRECTOR Edw R Tipton ADDRESS Hampstead Md

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
FEB 21 1955
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01445

CERTIFICATE OF DEATH

\# 1464 Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY CARROLL MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Sykesville
LENGTH OF STAY (in this place) 19 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4
STREET ADDRESS (If rural give location) 6126 Alta Avenue, Baltimore-6 ✓

3. NAME OF DECEASED: (Type or Print) (First) Ruth (Middle) Louise (Last) ALBRECHT
4. DATE OF DEATH: (Month) 2 (Day) 17 (Year) 1955
5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married
8. DATE OF BIRTH: 3/17/98
9. AGE last birthday 56 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Fred Meyer
14. MOTHER'S MAIDEN NAME: Ann K.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT & ADDRESS: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

331X
IMMEDIATE CAUSE (A) Pulmonary embolism — few hours
ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST
DUE TO (B) Cerebral vascular accident — few hours
DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Organic brain pathology pending further investigation — 1 year or more

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work [ ] Not while at work [ ]
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/29, 1955, to 2/17, 1955, that I last saw the deceased alive on 2/16, 1955, and that death occurred at 6:07AM, from the causes and on the date stated above.

SIGNATURE Walther H. Sonnenfeldt, M. D. ADDRESS Sykesville, Maryland DATE SIGNED 2/17/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 2/21/55
NAME OF CEMETERY OR CREMATORY Immanuel Cemetery
LOCATION (City, town, or county) (State) Balto. Md.

DATE REC'D BY LOCAL REGISTRAR February 19 1955
REGISTRAR'S SIGNATURE R.W. ✓
24. FUNERAL DIRECTOR ADDRESS Paul A. Heemann 6067 Harford Rd.

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01446

CERTIFICATE OF DEATH

1465

Reg. Dist. No. 77

1. PLACE OF DEATH:
COUNTY CARROLL MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Sykesville, Md.
LENGTH OF STAY (in this place) 6 mos. 25 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital Sykesville, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4
STREET ADDRESS (If rural give location) 1658 E. 25th Street, Baltimore-13

3. NAME OF DECEASED: (Type or Print) (First) ALICE (Middle) AGNES (Last) BAGNALL

4. DATE OF DEATH: (Month) 2/ (Day) 28 (Year) 1955

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: 5/5/75

9. AGE last birthday 79 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10B. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Ohio

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Carson

14. MOTHER'S MAIDEN NAME: Margaret Wolfe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk (If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO. none

17. INFORMANT & ADDRESS: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

002X
IMMEDIATE CAUSE (A) Bilateral pulmonary tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: 7 months

ANTECEDENT CAUSE (B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic brain syndrome associated with senile brain disease — 10 years

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/3/54 to 2/28/55, that I last saw the deceased alive on 2/28/55, and that death occurred at 10:45 M, from the causes and on the date stated above.

SIGNATURE Walther H. Brunnenfeldt M.D. ADDRESS Sykesville, Maryland DATE SIGNED 2/28/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF Mar. 2-56 — NAME OF CEMETERY OR CREMATORY Loudon — LOCATION (City, town, or county) (State) Baltimore, Md

DATE REC'D BY LOCAL REGISTRAR Feb. 28, 1955 — REGISTRAR'S SIGNATURE C. Henry Wm — 24. FUNERAL DIRECTOR Wm Cook Inc — ADDRESS Baltimore

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
MAR 4 1955
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1466 **CERTIFICATE OF DEATH** Reg. Dist. No. 01447 54

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Sykesville
LENGTH OF STAY (in this place) 2Y, 4M, 15 D
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Montgomery
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 06-56-2
STREET ADDRESS (If rural give location) 2311 Kimball Place ✓

3. NAME OF DECEASED: (Type or Print) (First) DORA (Middle) CECELIA (Last) BEALL

4. DATE OF DEATH: (Month) 2 (Day) 14 (Year) 1955

5. SEX: Female
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow
8. DATE OF BIRTH: 11/13/82
9. AGE last birthday 72 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Francis Frommeyer
14. MOTHER'S MAIDEN NAME: Sarah Kime

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) —
16. SOCIAL SECURITY NO. 202-18-8410
17. INFORMANT & ADDRESS: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

902.7 IMMEDIATE CAUSE	(A) Pulmonary thrombosis	instant
ANTECEDENT CAUSE (S) DUE TO		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(B) Hip Fracture	10 days
DUE TO		
	(C)	

II SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic brain syndrome associated with cerebral arteriosclerosis, with psychotic reaction — 7 years

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES X NO

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY hospital
21C. WHERE DID INJURY OCCUR? (City or town) Sykesville (County) Carroll (State) Md.
21D. TIME OF INJURY (Month) 2 (Day) 4 (Year) 55 (Hour) 11:45 AM.
21E. INJURY OCCURRED While at work ☐ Not while at work ☒
21F. HOW DID INJURY OCCUR? Patient fell from rocking chair to floor

22. I hereby certify that I attended the deceased from 2/4/55, 1955 to 2/14/, 1955, that I last saw the deceased alive on 2/14, 1955, and that death occurred at 8:50 A M, from the causes and on the date stated above.
SIGNATURE Walther H. Sonnenschein M. D. ADDRESS Sykesville, Maryland DATE SIGNED 2/14/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF Feb. 18, 1955
NAME OF CEMETERY OR CREMATORY St. Francis Cemetery
LOCATION (City, town, or county) (State) Gettysburg, Adams Co. Pa.
DATE REC'D BY LOCAL REGISTRAR Feb. 14, 1955
REGISTRAR'S SIGNATURE C. Henry Klee
24. FUNERAL DIRECTOR J. Milton Bender ADDRESS Gettysburg, Pa

VS. A15 — 10 - 53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 17 1955
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01448

1467 **CERTIFICATE OF DEATH** Reg. Dist. No. 74

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 14 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Washington
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clearspring
STREET ADDRESS (If rural give location) 2 / X - 2

3. NAME OF DECEASED: (Type or Print) (First) Mary (Middle) (Last) Brennan

4. DATE OF DEATH: (Month) Feb. (Day) 10 (Year) 1955

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single
8. DATE OF BIRTH: 7-12-1875
9. AGE last birthday 79 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper
10B. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Brennan
14. MOTHER'S MAIDEN NAME: Matilda Bowman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No. (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. [illegible]
17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

450.0
IMMEDIATE CAUSE (A) Pneumonia — Few days

ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST
DUE TO (B) Generalized arteriosclerosis — many years
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Psychosis with cerebral arteriosclerosis — many years

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐ Autopsy Pet

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-12-1940 to 2/10/, 1955, that I last saw the deceased alive on 2/9/, 1955, and that death occurred at 8:20 AM, from the causes and on the date stated above.
SIGNATURE A. Leitch M.D. ADDRESS Springfield Hospital DATE SIGNED 2/10/1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 2/12/55
NAME OF CEMETERY OR CREMATORY St Pauls
LOCATION (City, town, or county) (State) Clear Spring Md

DATE REC'D BY LOCAL REGISTRAR Feb 11, 1955
REGISTRAR'S SIGNATURE C. Harry Tilson
24. FUNERAL DIRECTOR Adrian H. Rowland ADDRESS Clear Spring Md

RECEIVED
FEB 1 4 1955
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01449

1468 **CERTIFICATE OF DEATH** Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Sykesville
LENGTH OF STAY (in this place) 1 year
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 3 Y O 1 4
STREET ADDRESS (If rural give location) 1729 Darley Avenue

3. NAME OF DECEASED: (Type or Print) (First) Daisy (Middle) (Last) Carlson

4. DATE OF DEATH: (Month) 2 - (Day) 26 (Year) 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 3-2-1878

9. AGE last birthday 76 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Not known

14. MOTHER'S MAIDEN NAME: Elizabeth ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No. (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. Unk.

17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X IMMEDIATE CAUSE (A) Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
DUE TO (B) Bronchopneumonia
DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Cerebral Arteriosclerosis

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION: 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-19, 1953, to 2-26, 1955, that I last saw the deceased alive on 2-26, 1955, and that death occurred at 2 P M, from the causes and on the date stated above.

SIGNATURE Gerhard Sonnenfeld M.D. ADDRESS Springfield State Hospital Sykesville Md. DATE SIGNED 2-27-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF Mar 2-55
NAME OF CEMETERY OR CREMATORY Cedar Bluff Cem
LOCATION (City, town, or county) Annapolis (State) Md.

DATE REC'D BY LOCAL REGISTRAR Feb 28, 1955
REGISTRAR'S SIGNATURE [illegible]
24. FUNERAL DIRECTOR John M. Taylor Sons ADDRESS Annapolis Md.

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
MAR 4 1955
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01450

1469 **CERTIFICATE OF DEATH** Reg. Dist. No. 71

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY CARROLL MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X UNION BRIDGE (Rural)
LENGTH OF STAY (in this place) 4 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS CO LINWOOD

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY CARROLL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Union Bridge Rural X
STREET ADDRESS (If rural give location) Linwood 1

3. NAME OF DECEASED: (Type or Print) (First) J (Middle) MAURICE (Last) CARR SR.

4. DATE OF DEATH: (Month) Feb (Day) 11 (Year) 1955

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M

8. DATE OF BIRTH: Feb 3 - 1903

9. AGE Last birthday: 52 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: own farm

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Albert Carr

14. MOTHER'S MAIDEN NAME: Lizzie Tracey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: none

17. INFORMANT & ADDRESS: Ada E. Carr, Union Bridge Rural

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Interval Between Onset And Death

331X
Immediate cause (a) Cerebral Hemorrhage DUE TO

Antecedent causes (s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: **19b. MAJOR FINDINGS OF OPERATION** **20. AUTOPSY?** Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) **PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. **INJURY OCCURED** While at Work ☐ Not While At Work ☐ **HOW DID INJURY OCCUR?**

22. I hereby certify that I attended the deceased from 2/10, 1955, to 2/11, 1955, that I last saw the deceased alive on 2/10, 1955 and that death occurred at 6 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) T. H Legg MD ADDRESS Union Bridge Md DATE SIGNED 2/11/55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial **DATE THEREOF** 2/14/55 **NAME OF CEMETERY OR CREMATORY** Pipe Creek **LOCATION** (City, town, or county) Carroll Co. (State) Maryland

DATE REC'D BY LOCAL REGISTRAR Feb. 12/55 **REGISTRAR'S SIGNATURE** Margaret R. Englar

24. FUNERAL DIRECTOR W. D. Hartsock & Sons **ADDRESS** New Windsor

1479

01451

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 74

1. PLACE OF DEATH:
COUNTY CARROLL MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Sykesville
LENGTH OF STAY (in this place) 24y 11m 3 wks
HOSPITAL OR INSTITUTION OR STREET ADDRESS SPRINGFIELD STATE HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN BALTIMORE 3V01-4
STREET ADDRESS (If rural, give location) Wyndam Park Apts 1

3. NAME OF DECEASED: (Type or Print) (First) HORACE (Middle) STANLEY (Last) CHASE
4. DATE OF DEATH (Month) 2 (Day) 21 (Year) 1955
5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) divorced
8. DATE OF BIRTH: 8/19/1883
9. AGE last birthday: 71 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Broker
10b. KIND OF BUSINESS OR INDUSTRY: Unk.
11. BIRTHPLACE (State or foreign country): Connecticut
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Horace Gair Chase
14. MOTHER'S MAIDEN NAME: ELLEN M. Shereuin
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Unk.
17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) RUPTURE of HEART — Interval Between Onset and Death: instant

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) INFARCTION of MYOCARD - — minutes

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Fracture of Rt. hip, Hardening, Manic depress. psych. — 13 days, 25 yrs. +

19a. DATE OF OPERATION:
19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY
21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.
21e. INJURY OCCURRED While at work ☐ Not while at work ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE James T Shanks M. D.
CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☒
DATE SIGNED 2/21/55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF 2-28-55
NAME OF CEMETERY OR CREMATORY Concord
LOCATION (City, town, or county) (State) Concord, New Hampshire

DATE REC'D BY LOCAL REG. Feb. 25, 1955
REGISTRAR'S SIGNATURE C. Harry Weis
24. FUNERAL DIRECTOR ADDRESS Walter A. Knight & Sons, Sykesville, Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

RECEIVED
MAR 4 1955
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01452

1471 **CERTIFICATE OF DEATH** Reg. Dist. No.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
MARYLAND
LENGTH OF STAY (in this place) 1month4days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 SPRINGFIELD STATE HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City (18)
STREET ADDRESS (If rural give location) 4 E. 32nd Street

3. NAME OF DECEASED. (Type or Print) (First) KATE (Middle) WARREN (Last) CONSTANTINE

4. DATE OF DEATH (Month) February (Day) 15 (Year) 1955

5. SEX Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Single

8. DATE OF BIRTH. 5-19-1860

9. AGE last birthday 94 yrs | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teacher- Retired

10B. KIND OF BUSINESS OR INDUSTRY: School

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME. Daniel I. Constantine

14. MOTHER'S MAIDEN NAME: Katherine Kneip

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

421.0 IMMEDIATE CAUSE (A) Bilateral Bronchopneumonia (terminal) — INTERVAL BETWEEN ONSET AND DEATH: 24hrs.

ANTECEDENT CAUSE (B) DUE TO Mitral heart disease with old infarct — years.

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) DUE TO generalized arteriosclerosis — years.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE CBS assoc. with disturbance of metabolism, OR CONDITION CAUSING DEATH growth or nutrition, with senile brain disease, 4 years

19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION with psychotic reaction.

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21E. INJURY OCCURRED While at work [ ] Not while at work [ ]

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-11, 1955, to 2-15, 1955, that I last saw the deceased alive on 2-15, 1955, and that death occurred at 7:10 P M, from the causes and on the date stated above.

SIGNATURE Walter L. Sonnenfeld M.D. ADDRESS Springfield State Hospital DATE SIGNED 2-16-55

23. BURIAL, CREMATION REMOVAL (SPECIFY) Burial — DATE THEREOF Feb. 18, 1955 — NAME OF CEMETERY OR CREMATORY New Cathedral Cem. — LOCATION (City, town, or county) (State) Baltimore, Md.

DATE REC'D BY LOCAL REGISTRAR Feb 17 1955 — REGISTRAR'S SIGNATURE C. W. Hedrick

24. FUNERAL DIRECTOR John A. Moran — ADDRESS 3000 E. Baltimore St.

VS. A15—10-53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01453

1472 CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 7 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY ----
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City
STREET ADDRESS (If rural give location) 123 East Barney St.

3. NAME OF DECEASED: (Type or Print) (First) Joseph (Middle) Thomas (Last) Coulford

4. DATE OF DEATH: (Month) Feb (Day) 12 (Year) 1955

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) married
8. DATE OF BIRTH: 10-3-1888
9. AGE last birthday 66 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) sheet metal worker
10B. KIND OF BUSINESS OR INDUSTRY: Unk.
11. BIRTHPLACE (State or foreign country): Baltimore, Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Coulford
14. MOTHER'S MAIDEN NAME: Molly Bladrely

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) ? (If Yes, give war or dates of service) ?
16. SOCIAL SECURITY NO. ?
17. INFORMANT & ADDRESS: Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0
IMMEDIATE CAUSE (A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 6 days

ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST
DUE TO (B) Arteriosclerotic heart disease — more than 9 yrs.
DUE TO (C)

II SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE OR CONDITION CAUSING DEATH. Psychosis with cerebral arteriosclerosis — 9 yrs

19A. DATE OF OPERATION: ----
19B. MAJOR FINDINGS OF OPERATION: ----
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) ----
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) ----
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. ----
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR? ----

22 I hereby certify that I attended the deceased from 6 - 23, 1948, to 2 - 12, 1955, that I last saw the deceased alive on 2 - 12, 1955, and that death occurred at 6:40 P M, from the causes and on the date stated above.

SIGNATURE Martin Gross, M.D. Martin Gross, M.D. — ADDRESS M.D Sykesville, Md — DATE SIGNED Feb. 12, 1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 2-15-55
NAME OF CEMETERY OR CREMATORY London Tuck
LOCATION (City, town, or county) (State) Balto. Md.

DATE REC'D BY LOCAL REGISTRAR Feb 13, 1955
REGISTRAR'S SIGNATURE C. Henry Ickes
24. FUNERAL DIRECTOR Filpon & Fleming
ADDRESS 1426 Eight St.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1473

CERTIFICATE OF DEATH

01454

Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Sykesville
LENGTH OF STAY (in this place) 2 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Montgomery
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brookville
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) SAMUEL (Middle) White (Last) DARNE

4. DATE OF DEATH: (Month) 2 (Day) 4 (Year) 1955

5. SEX: m

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widower

8. DATE OF BIRTH: 11/26/80

9. AGE last birthday: 74 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10B. KIND OF BUSINESS OR INDUSTRY: Agriculture

11. BIRTHPLACE (State or foreign country): Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Alexander Darne

14. MOTHER'S MAIDEN NAME: Ruth E. Darby

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO. Unk.

17. INFORMANT & ADDRESS: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X

IMMEDIATE CAUSE (A) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSE (B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) General arteriosclerosis — years

(C) DUE TO

SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE OR CONDITION CAUSING DEATH Chronic brain syndrome associated with cerebral arteriosclerosis, with psychotic react. 14 years

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/21, 1955, to 2/4/, 1955, that I last saw the deceased alive on 2/4/, 1955, and that death occurred at 2:45 PM, from the causes and on the date stated above.

SIGNATURE Edmund Leuthaus M.D. ADDRESS Sykesville, Maryland DATE SIGNED 2/4/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF 2-7-55 — NAME OF CEMETERY OR CREMATORY Chestnut Grove — LOCATION (City, town, or county) Herndon, Va. (State)

DATE REC'D BY LOCAL REGISTRAR Feb. 6, 1955 — REGISTRAR'S SIGNATURE C. Harry Mills

24. FUNERAL DIRECTOR Money & King — ADDRESS Vienna, Va.

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 1455

1474

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (In this place) 1 year
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Chevy Chase
STREET ADDRESS (If rural give location) 4898 Chevy Chase Blvd.

3. NAME OF DECEASED: (Type or Print) (First) Caroline (Middle) Anna (Last) Doying

4. DATE OF DEATH: (Month) Feb. (Day) 14 (Year) 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widow

8. DATE OF BIRTH: 10-17-1874

9. AGE last birthday: 80 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: ---Home

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lewis Huner

14. MOTHER'S MAIDEN NAME: Marie Lipp

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No. (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. Unk

17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1
IMMEDIATE CAUSE (A) Broncho-pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 wks

ANTECEDENT CAUSE (B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) Cardio-vascular disease — years

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. CBS associated with cerebral arteriosclerosis with psychosis — years

19A. DATE OF OPERATION: —

19B. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — M.

21E. INJURY OCCURRED While at work [ ] Not while at work [ ]

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/17, 1954, to 2/14, 1955, that I last saw the deceased alive on 2/13/, 1955, and that death occurred at 8:15 aM, from the causes and on the date stated above.

SIGNATURE A. Labiga M.D ADDRESS Springfield Hospital DATE SIGNED 2/14/1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF 2-16-1955

NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.

LOCATION (City, town, or county) (State) Suitland Md.

DATE REC'D BY LOCAL REGISTRAR Feb. 14, 1955

REGISTRAR'S SIGNATURE C. Harry Eder

24. FUNERAL DIRECTOR Chevy Chase Funeral Home ADDRESS Wash. D.C.

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01456

1458

CERTIFICATE OF DEATH

Reg. Dist. No. 52

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
LENGTH OF STAY (in this place) 22 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 17 E. Main

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
STREET ADDRESS (If rural, give location) 17 E. Main

3. NAME OF DECEASED: (Type or Print) (First) CLARENCE (Middle) CARR (Last) DRYDEN

4. DATE OF DEATH: (Month) Feb. (Day) 19 (Year) 1955

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: May 7-1875

9. AGE last birthday: 79 yrs. — IF UNDER 1 YEAR: Months Days — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret Employee

10b. KIND OF BUSINESS OR INDUSTRY: Gas & Electric Co.

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Dryden

14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 212-05-3279

17. INFORMANT & ADDRESS: Mrs Myrtle Magin 53 Church St. Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:
Immediate cause (a) Myocardial degeneration — DUE TO
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) — DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH: 1 yr

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Bronchial asthma — 25 yrs

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY M.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 28, Feb. 19 19 55 to Feb. 19 19 55 that I last saw the deceased alive on Feb. 19, 1955, and that death occurred at 5:45 A.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS — DATE SIGNED
Wilbur Wilkens M.D. Westminster Md. 2/22/55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF Feb 22-1955 — NAME OF CEMETERY OR CREMATORY Meadow Branch Cem. — LOCATION (City, town, or county) Westminster — (State) Md.

DATE REC'D BY LOCAL REG. Feb 22 1955 — REGISTRAR'S SIGNATURE Hamilton Miller — **24. FUNERAL DIRECTOR** H. D. Bankard & Son — ADDRESS Westminster, Md.

1475

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 01457 34

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Sykesville
MARYLAND LENGTH OF STAY (in this place) 5 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED.
STATE Maryland COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
STREET ADDRESS (If rural give location) 2901 Alameda, Baltimore, Md.

3. NAME OF DECEASED: (Type or Print) (First) JOHN (Middle) ROBERT (Last) Etridge, Sr.

4. DATE OF DEATH: (Month) 2/ (Day) 6 (Year) 1955

5. SEX: Male | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed | 8. DATE OF BIRTH: 7/26/87 | 9. AGE last birthday 67 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman

10B. KIND OF BUSINESS OR INDUSTRY: Unk -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Patrick Etridge

14. MOTHER'S MAIDEN NAME: Katherine - ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) -

16. SOCIAL SECURITY NO. Unk -

17. INFORMANT & ADDRESS: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE	(A) Bronchopneumonia	1 day
ANTECEDENT CAUSE (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(B) DUE TO Arteriosclerotic heart disease	years
	(C) Parotitis, septic	2 days
SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	Chronic brain syndrome associated with cerebral arteriosclerosis, psychotic react.	3 weeks

19A. DATE OF OPERATION: /

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/1/ , 1955, to 2/6/55 19 , that I last saw the deceased alive on 2/6/55 , 19 , and that death occurred at 7:55 P.M. from the causes and on the date stated above.

SIGNATURE Edmund Lusthaus M.D. ADDRESS Sykesville, Maryland DATE SIGNED 2/7/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 2-1-55 | NAME OF CEMETERY OR CREMATORY [illegible] | LOCATION (City, town, or county) [illegible] (State)

DATE REC'D BY LOCAL REGISTRAR Feb 7, 1955 | REGISTRAR'S SIGNATURE C. Harry Weis

24. FUNERAL DIRECTOR W. M. Cook, Inc. | ADDRESS 1217 [illegible]

01458

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1476 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH.
COUNTY Carroll — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Sykesville
LENGTH OF STAY (in this place) 28Y5M 4D
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4
STREET ADDRESS (If rural give location) unknown

3. NAME OF DECEASED. (Type or Print) (First) JACOB (Middle) (Last) FORLOREN (Vanlewuen)

4. DATE OF DEATH: (Month) 2 (Day) 4 (Year) 1955

5. SEX M — 6. COLOR OR RACE: W — 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) single — 8. DATE OF BIRTH: 1880 — 9. AGE last birthday 74 yrs — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Holland
12. CITIZEN OF WHAT COUNTRY? Unk

13. FATHER'S NAME: Joseph Vanlewuen
14. MOTHER'S MAIDEN NAME: Unk

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) —
16. SOCIAL SECURITY NO. none
17. INFORMANT & ADDRESS. Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
331X IMMEDIATE CAUSE	(A) cerebral hemorrhage	one day
ANTECEDENT CAUSE (B)	DUE TO (B) generalized Arteriosclerosis	Years
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST	DUE TO (C) Severe stasis-ulcer on R leg back	months
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE OR CONDITION CAUSING DEATH	Mental Deficiency	since birth

19A. OPERATION: — 19B. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/21/ , 19 55 to 2/4/ , 1955, that I last saw the deceased alive on 2/3/ , 19 55, and that death occurred at 12:05 A M, from the causes and on the date stated above.

SIGNATURE Walter H Sonnenfeldt M. D. ADDRESS Sykesville, Maryland DATE SIGNED 2/4/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF 2-15-55 — NAME OF CEMETERY OR CREMATORY Springfield — LOCATION (City, town, or county) (State) Gaymeadow, Md.

DATE REC'D BY LOCAL REGISTRAR Feb. 15, 1955 — REGISTRAR'S SIGNATURE E. Haney, Asst. — 24. FUNERAL DIRECTOR Arnold H. Wright — ADDRESS Sykesville, Md.

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01459

CERTIFICATE OF DEATH

1477

Reg. Dist. No. 78

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) X TOWN rural--Westminster
LENGTH OF STAY (in this place) life
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN rural--Westminster X
STREET ADDRESS (If rural, give location) 1

3. NAME OF DECEASED: (Type or Print) (First) ERNEST (Middle) R. (Last) FRANKLIN

4. DATE OF DEATH: (Month) FEB. (Day) 24, (Year) 19 55

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married

8. DATE OF BIRTH: 8-5-1879

9. AGE last birthday: 75 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer (retired)

10b. KIND OF BUSINESS OR INDUSTRY: owner

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Nathan Franklin

14. MOTHER'S MAIDEN NAME: Sarah ??

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no

16. SOCIAL SECURITY NO.: none

17. INFORMANT & ADDRESS: Mrs. Clara Franklin, WestminsterMd.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

422.1

Immediate cause (a) Arterio & Clerotic C-V disease — Interval Between Onset and Death: years

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b)

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Carcinoma of bladder. years.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from —, 1950, to Feb 24, 1955, that I last saw the deceased alive on Feb 22, 1955, and that death occurred at 2 a.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED

James J. Harrold M.D. Westminster Md 2/24/55

23. BURIAL, CREMATION REMOVAL (Specify): BURIAL

DATE THEREOF 2-26-1955

NAME OF CEMETERY OR CREMATORY Sams Creek Brethren

LOCATION (City, town, or county) (State) Carroll Co., Maryland

DATE REC'D BY LOCAL REG. 2-26-55

REGISTRAR'S SIGNATURE E. M. Farver

24. FUNERAL DIRECTOR ADDRESS C. M. Waltz, Winfield, Maryland

Local

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1478

01460 Reg. Dist. No.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH: COUNTY Carroll MARYLAND; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville; LENGTH OF STAY (in this place) 1yr.8mo.4days; HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City; STREET ADDRESS (If rural give location) 3138 McElderry Street

3. NAME OF DECEASED: (Type or Print) (First) CHARLES (Middle) HENRY (Last) FREESE

4. DATE OF DEATH: (Month) (Day) (Year) February 15 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: 5-25-95

9. AGE last birthday: 59 yrs. IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10B. KIND OF BUSINESS OR INDUSTRY: Columbia Specialty

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry John Freese

14. MOTHER'S MAIDEN NAME: Mary Lillian East

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 213-01-0904

17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Pulmonary tuberculosis, far-advanced — INTERVAL BETWEEN ONSET AND DEATH: 12 years

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (B) DUE TO

(C)

II SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Schizophrenic reaction, paranoid type. — 15 years+

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-11, 1953, to 2-15, 1955, that I last saw the deceased alive on 2-14, 1955, and that death occurred at 12:35 AM, from the causes and on the date stated above.

SIGNATURE Walter H Sonnenfeldt, M D — ADDRESS Springfield State Hospital — DATE SIGNED 2-15-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF 2/18/55 — NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem. — LOCATION (City, town, or county) (State) Belair Rd., Balto. Md.

DATE REC'D BY LOCAL REGISTRAR 2/17/55 — REGISTRAR'S SIGNATURE A. C. Hedrick — 24. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 2601-3-5 E. Madison St.

01461

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1459

CERTIFICATE OF DEATH

Reg. Dist. No. 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
LENGTH OF STAY (in this place) 12 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 145 Liberty St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
STREET ADDRESS (If rural, give location) 145 Liberty St.

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH: (Month)	(Day)	(Year)
MINERVA	JANE	GAHLE	Feb.	16	1955

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
F	W	Widow	March 26 1883	71 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Housewife		Maryland	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Israel Utz	Katharine Snyder

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
No	none	Mrs Anna D Smith 145 Liberty St. Westminster Md.

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
Immediate cause	(a) Lobar Pneumonia	4 days
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) Cerebral Hemmorhage	2 MOS
DUE TO		
	(c)	
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.	(1) Diabetes Mellitus, (2) Hypertension	(1) 1 Year (2) 3 Yrs

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY?
		Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
M.		

22. I hereby certify that I attended the deceased from Nov., 1952 to Jan 16, 1955, that I last saw the deceased alive on Jan 16, 1955, and that death occurred at 12:25 P.M., from the causes and on the date stated above.

SIGNATURE Julian Chepko (DEGREE OR TITLE) M.D. ADDRESS 130 E. Green Westminster Md. DATE SIGNED 2/17/55

23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Feb. 18. 1955	Westminster Cemetery	Westminster Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
	Feb. 17. 1955 Harold Miller	H. Bankard & Son	Westminster, Md.

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1479

CERTIFICATE OF DEATH

01462

Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Henryton
MARYLAND
LENGTH OF STAY (in this place) 1 day
HOSPITAL OR INSTITUTION OR STREET ADDRESS Henryton State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland
COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural give location) 1211 Caen Street

3. NAME OF DECEASED: (First) ARTHUR (Middle) (Last) HALL
4. DATE OF DEATH: (Month) Feb. (Day) 16 (Year) 1955
5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Divorced
8. DATE OF BIRTH: Dec. 24, 1913
9. AGE last birthday: 41 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): PBX operator
10b. KIND OF BUSINESS OR INDUSTRY: Balto. Country Club
11. BIRTHPLACE (State or foreign country): Wilson, N.C.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Frank Hall
14. MOTHER'S MAIDEN NAME: Elizabeth Haigler
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: 213-01-4250
17. INFORMANT & ADDRESS: Deceased

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
Immediate cause (a) 002X
DUE TO
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Pulmonary tuberculosis
DUE TO
(c) Cardiovascular insufficiency

Interval Between Onset And Death: 2 yrs 10 mos

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-14-55, to 2-16-55, that I last saw the deceased alive on 2-16-55, and that death occurred at 7:a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) I. Pleasal M.D. ADDRESS Henryton, Md. DATE SIGNED 2-16-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 2-19-55
NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.
LOCATION (City, town, or county) Balto. Md (State)
DATE REC'D BY LOCAL REGISTRAR 2-18-54
REGISTRAR'S SIGNATURE Albert R. Smallhouse Deputy Local
24. FUNERAL DIRECTOR William D. Chatman Jr. ADDRESS 1701 McCulloh St

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01463

1430

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN HENRYTON
LENGTH OF STAY (in this place) 1½ hours
HOSPITAL OR INSTITUTION OR STREET ADDRESS 03 HENRYTON STATE HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 3V 4
STREET ADDRESS (If rural give location) 511 Bradley Street

3. NAME OF DECEASED: (First) ~~ISRAEL~~ (Middle) Israel (Last) HAYNES
4. DATE OF DEATH: (Month) 2 (Day) 11 (Year) 1955
5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: 8-33-32
9. AGE last birthday: 22 yrs. — IF UNDER 1 YEAR: Months Days — IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Unknown
11. BIRTHPLACE (State or foreign country): South Carolina
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Monnie Kennet
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: Unknown
17. INFORMANT & ADDRESS: Geo. G. Elson, 1348 N. Calhoun St.,

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause — (a) Far adv. bilat. pul. Tbc. — Interval Between Onset And Death: 6 weeks plus

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. — DUE TO (b) — DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-11 ,19 55, to 2-11 , 1955 , that I last saw the deceased alive on 2-11- ,19 55, and that death occurred at 3:45 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): T.F. Flegal M.D. — ADDRESS: Henryton, Md. — DATE SIGNED: 2-11-55

23. BURIAL, CREMATION, REMOVAL (Specify) — DATE THEREOF: Feb 16, 1955 — NAME OF CEMETERY OR CREMATORY: Mt Auburn — LOCATION (City, town, or county) (State): Md

DATE REC'D BY LOCAL REGISTRAR: 2-11-55 — REGISTRAR'S SIGNATURE: Albert R. Smith Deputy Local — 24. FUNERAL DIRECTOR: George G. Elson — ADDRESS: 1348 N. Calhoun St

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01464

* 1491 CERTIFICATE OF DEATH Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY CARROLL MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Sykesville
LENGTH OF STAY (in this place) 17 Y 11 M 18 D
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Washington COUNTY Md.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown 21-03-2
STREET ADDRESS (If rural give location) 37 North Avenue

3. NAME OF DECEASED (Type or Print): (First) ALFRED (Middle) GARFIELD (Last) HENNEBERGER

4. DATE OF DEATH: (Month) 2 (Day) 14 (Year) 1955

5. SEX: Male | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M | 8. DATE OF BIRTH: 5/8/80 | 9. AGE last birthday: 74 yrs. | IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS.: Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10B. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Alfred Henneberger

14. MOTHER'S MAIDEN NAME: Mary ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk.

16. SOCIAL SECURITY NO. (If Yes, give war or dates of service) Unk.

17. INFORMANT & ADDRESS: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

21X

IMMEDIATE CAUSE (A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 5 hours

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (B) DUE TO

(C)

SIGNIFICANT CONDITIONS CONTRIBUTING DEATH BUT NOT RELATED TO THE OR CONDITION CAUSING DEATH. Chronic Brain Syndrome asso. with General Paresis 29 yrs

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/11, 1954, to 2/14, 1955, that I last saw the deceased alive on 2/14, 19 55, and that death occurred at 5:00 PM, from the causes and on the date stated above.

SIGNATURE Walther H. Sonnenfeldt. M. D. ADDRESS Sykesville, Maryland DATE SIGNED 2/14/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | DATE THEREOF 2/16/55 | NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | LOCATION (City, town, or county) Hagerstown Md. (State)

DATE REC'D BY LOCAL REGISTRAR Feb. 14, 1955 | REGISTRAR'S SIGNATURE C. Harry Klein

24. FUNERAL DIRECTOR Suter Fun. Home | ADDRESS Hag. Md.

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01465

CERTIFICATE OF DEATH

1432 Reg. Dist. No.

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Sykesville
LENGTH OF STAY (in this place) 25 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ~~Westminster~~ Manchester. R 1
STREET ADDRESS (If rural give location) W. Main St.

3. NAME OF DECEASED (Type or Print): (First) MARGARET (Middle) JOSEPHINE (Last) HOUCK

4. DATE OF DEATH: (Month) 2 (Day) 3 (Year) 1955

5. SEX: Female
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widowed
8. DATE OF BIRTH: 10/8/67
9. AGE last birthday ~~88~~ 87 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George W. Trump
14. MOTHER'S MAIDEN NAME: ~~Mary Jane~~ Martha Garber

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT & ADDRESS: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X IMMEDIATE CAUSE (A) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (B) DUE TO generalized arteriosclerosis — years

(C) hypertensive cardiovascular disease — years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic brain syndrome associated with senile brain disease — years

19A. OPERATION: 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/31, 1955, to 2/3, 1955 that I last saw the deceased alive on 2/3, 1955, and that death occurred at 1:15P M, from the causes and on the date stated above.

SIGNATURE Walter H. Sommerfeldt M. D. ADDRESS Sykesville, Md. DATE SIGNED 2/3/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 2/6/55
NAME OF CEMETERY OR CREMATORY Manchester Cem.
LOCATION (City, town, or county) (State) Manchester Carroll Md

DATE REC'D BY LOCAL REGISTRAR 2/7/55
REGISTRAR'S SIGNATURE C. Thomas Myer
24. FUNERAL DIRECTOR ADDRESS R D Wink Manchester Md

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

* 1483 MARYLAND STATE DEPARTMENT OF HEALTH 01466

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

M

VS. A15

1. PLACE OF DEATH: COUNTY Carroll — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Manchester — LENGTH OF STAY (in this place) 2 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS Longview Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hampstead — X
STREET ADDRESS (If rural, give location) 15 South MAIN

3. NAME OF DECEASED (Type or Print): (First) Lilly (Middle) May (Last) Humm (Human)
4. DATE OF DEATH: (Month) February (Day) 21 (Year) 1955
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow
8. DATE OF BIRTH: Sept 6, 1887
9. AGE last birthday: 67 yrs. — If under 1 year: Months — Days — If under 24 hrs.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John H Gillis
14. MOTHER'S MAIDEN NAME: Maggie Poole
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: None
17. INFORMANT AND ADDRESS: Mrs Margaret Campbell: Hampstead Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) 442X Chronic Myocarditis

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive Cardio Renal Vascular Lesion ?

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 9, 1954, to February 21, 1955, that I last saw the deceased alive on February 18, 1955, and that death occurred at 2 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Joseph E Bush MD Hampstead Md Feb 21, 1955

23. BURIAL, CREMATION, REMOVAL (Specify) — DATE THEREOF: Feb. 23/55 — NAME OF CEMETERY OR CREMATORY: Glen Haven — LOCATION (City, town, or county) (State): Glen Burnie, Md

DATE REC'D BY LOCAL REG.: Feb 23, 1955 — REGISTRAR'S SIGNATURE: Mrs. H. R. Adenner — L. J. D'Alba

24. FUNERAL DIRECTOR — ADDRESS: Glen Burnie Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01467

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1460

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
LENGTH OF STAY (in this place) 10 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 161 W. Main

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
STREET ADDRESS (If rural, give location) 161 W. Main

3. NAME OF DECEASED: (First) EDITH (Middle) (Last) HUTCHINS

4. DATE OF DEATH: (Month) Feb. (Day) 10 (Year) 1955

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: Sept. 10 1886

9. AGE last birthday: 68 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seamstress

10b. KIND OF BUSINESS OR INDUSTRY: [illegible] Co.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William F. Hutchins

14. MOTHER'S MAIDEN NAME: Mary Abbie Webb

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 212-24-5062

17. INFORMANT & ADDRESS: Walter F. Hutchins 161 W. main Westminster Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

1747
Immediate cause (a) Acute Cardiac Dilatation — DUE TO — Interval between onset and death: 12 hrs

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
(b) Carcinoma Uterus — DUE TO — Interval between onset and death: 4 yrs
(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-26-, 1952, to 2-10-, 1955, that I last saw the deceased alive on 2-9-, 1955, and that death occurred at 2 A m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED
Chas. R. Foutz M.D. Westminster Md 2-10-55

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: Feb. 12, 1955 — NAME OF CEMETERY OR CREMATORY: Pine Grove Cemetery — LOCATION (City, town, or county) (State): Mt. Airy Md.

DATE REC'D BY LOCAL REG. — REGISTRAR'S SIGNATURE — 24. FUNERAL DIRECTOR — ADDRESS
Feb 11 1955 Hannah Miller H. Bankard Son Westminster Md.

VS. A15 8-51

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01468

14340 **CERTIFICATE OF DEATH** Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 23 hrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 4
STREET ADDRESS (If rural give location) 419 S. Chester Street

3. NAME OF DECEASED: (Type or Print) (First) Anna (Middle) Krukowski-Jakubowski (Last) JAKUBIAK
4. DATE OF DEATH: (Month) 2 (Day) 19 (Year) 1955
5. SEX: F.
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH: 8- ? - 1885
9. AGE last birthday 70 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Pulaski
14. MOTHER'S MAIDEN NAME: U
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. u
17. INFORMANT & ADDRESS: Mrs. Pictor 5322 Holder Avenue, Balto.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1
IMMEDIATE CAUSE (A) Myocardial Infarction — 2 hours
ANTECEDENT CAUSE (B) DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (B) Coronary Thrombosis — 8 hours
DUE TO
(C) Arteriosclerotic cardiovascular disease — years

SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2- 18- , 1955, to 2- 19- , 1955, that I last saw the deceased alive on 2- 19- , 1955, and that death occurred at 6:15 PM, from the causes and on the date stated above.
SIGNATURE Edmund Lusthaus M. D. ADDRESS Springfield State Hospital DATE SIGNED 2- 20- 1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Buried — DATE THEREOF Feb. 22/55 — NAME OF CEMETERY OR CREMATORY Sacred Heart of Mary — LOCATION (City, town, or county) Baltimore (State)

DATE REC'D BY LOCAL REGISTRAR 2-21-55 — REGISTRAR'S SIGNATURE A W Perkins — 24. FUNERAL DIRECTOR Fred W Ozazewski — ADDRESS 1930 Eastern Ave

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01469

1485 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY CARROLL — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville
LENGTH OF STAY (in this place) 17 Mo. 18 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Chevy Chase, Maryland
STREET ADDRESS (If rural give location) 6301 Delaware Street

3. NAME OF DECEASED: (Type or Print) (First) FRANCES (Middle) HOWE (Last) JOHNSON

4. DATE OF DEATH: (Month) 2 (Day) 15 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widowed

8. DATE OF BIRTH: 11/25/78

9. AGE last birthday: 76 yrs. IF UNDER 1 YEAR, Months Days; IF UNDER 24 HRS., Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): not reported

10B. KIND OF BUSINESS OR INDUSTRY: Unk -

11. BIRTHPLACE (State or foreign country): Missouri

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk - (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT & ADDRESS: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1
IMMEDIATE CAUSE (A) Myocardial infarct — INTERVAL BETWEEN ONSET AND DEATH: 72 hrs.

ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST
DUE TO (B) Arteriosclerotic cardiovascular disease — years
DUE TO (C)

SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE OR CONDITION CAUSING DEATH. Chronic Brain syndrome associated with cerebral arteriosclerosis, with psychotic reaction — 6 mos.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/28, 1954, to 2/15, 1955, that I last saw the deceased alive on 2/14, 19 55 and that death occurred at 3:00 P.M., from the causes and on the date stated above.

SIGNATURE Walter H Sonnenfield, M. D. ADDRESS Sykesville, Maryland DATE SIGNED 2/15/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF 2-17-55 — NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery — LOCATION (City, town, or county) (State) Pierce Virginia

DATE REC'D BY LOCAL REGISTRAR Feb. 16, 1955 — REGISTRAR'S SIGNATURE C. Hammond

24. FUNERAL DIRECTOR Robert A Dempsey — ADDRESS Laurel Md

VS. A15—10-53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01470

CERTIFICATE OF DEATH

1486

Reg. Dist. No. 74

1. PLACE OF DEATH.
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (In this place) 18yr5mo21days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 SPRINGFIELD STATE HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED.
STATE Maryland COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3004
STREET ADDRESS (If rural give location) Unk -

3. NAME OF DECEASED. (Type or Print) (First) CARRIE (Middle) S. (Last) JUDD

4. DATE OF DEATH. (Month) (Day) (Year) February 15 1955

5. SEX: Female | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Divorced | 8. DATE OF BIRTH: 1887 | 9. AGE last birthday: 68 yrs | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory worker | 10B. KIND OF BUSINESS OR INDUSTRY: Unk - | 11. BIRTHPLACE (State or foreign country): Virginia | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Judd

14. MOTHER'S MAIDEN NAME: Unk -

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No | (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. Unk -

17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

1711 IMMEDIATE CAUSE (A) Cancer of the cervix with wide-spread metastasis. — INTERVAL BETWEEN ONSET AND DEATH: Years

ANTECEDENT CAUSE (B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (B) DUE TO

(C)

SIGNIFICANT CONDITIONS CONTRIBUTING DEATH BUT NOT RELATED TO THE OR CONDITION CAUSING DEATH. Paranoid condition — Many Years

19A. DATE OF OPERATION. | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-11, 1954 to 2-15, 1955 that I last saw the deceased alive on 2-15, 1955, and that death occurred at 7:00 P M, from the causes and on the date stated above.

SIGNATURE Walter H. Sonnenfeldt M.D. ADDRESS Springfield State Hospital DATE SIGNED 2-16-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) | DATE THEREOF 2-19-55 | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REGISTRAR Feb 16, 1955 | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS. A1 — 10-53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1487 CERTIFICATE OF DEATH

Reg. Dist. No. 01474

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville
MARYLAND LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY ——
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City
STREET ADDRESS (If rural give location) 29 S. Highland Ave

3. NAME OF DECEASED (Type or Print): (First) Jacob (Middle) —— (Last) Kestner

4. DATE OF DEATH: (Month) Feb. (Day) 24 (Year) 1955

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married

8. DATE OF BIRTH: Nov. 3, 1873

9. AGE last birthday: 81 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer

10B. KIND OF BUSINESS OR INDUSTRY: ——

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ????

14. MOTHER'S MAIDEN NAME: ????

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) ——

16. SOCIAL SECURITY NO. 213-09-0275

17. INFORMANT & ADDRESS: Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

331X

IMMEDIATE CAUSE (A) Cerebro-vascular accident — 3 days

ANTECEDENT CAUSE (B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Generalized arteriosclerosis more — more than 1 yr.

DUE TO (C)

II SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Psychosis with cerebr. arteriosclerosis — more than 1 yr.

19A. OPERATION: ——

19B. MAJOR FINDINGS OF OPERATION: ——

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3 - 6, 1954, to 2 - 24, 1955, that I last saw the deceased alive on 2 - 24, 1955, and that death occurred at 10:35AM, from the causes and on the date stated above.

SIGNATURE Martin Gross, M.D. M.D. — ADDRESS Sykesville, Md — DATE SIGNED Feb. 24, 1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF Feb 28, 1955 — NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery — LOCATION (City, town, or county) (State) Baltimore, Maryland

DATE REC'D BY LOCAL REGISTRAR February 26 1955 — REGISTRAR'S SIGNATURE R.W.

24. FUNERAL DIRECTOR John A. Moran, ADDRESS 3000 E. Baltimore St.
for Edwin M. Stuby

01473

1461

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 7 6

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
LENGTH OF STAY (in this place) 55 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 32 W. George St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
STREET ADDRESS (If rural, give location) 32 W. George St.

3. NAME OF DECEASED (Type or Print): (First) Eva (Middle) Olivia (Last) Knadler
4. DATE OF DEATH: (Month) Feb. (Day) 27 (Year) 19 55

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: May 18, 1887
9. AGE last birthday: 67 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House work
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Keddysville, Maryland
12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: Samuel J. Knadler
14. MOTHER'S MAIDEN NAME: Annie V. Shewbridge

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): ------
16. SOCIAL SECURITY NO.: ---------
17. INFORMANT AND ADDRESS: Jessie N. Knadler Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

260 7 Immediate cause (a) Acute nephritis — Interval between onset and death: 8 weeks

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Acute Septic Sorethroat — 1 week

(c) Diabetes Mellitus — 4 yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 10th, 1954, to Feb. 27th, 1955, that I last saw the deceased alive on Feb 26, 1955, and that death occurred at 7 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) F. Linden Byers M.D. ADDRESS Westminster Maryland DATE SIGNED 3/28/55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: Mar. 1, 1955
NAME OF CEMETERY OR CREMATORY: Westminster Cemetery
LOCATION (City, town, or county) (State): Westminster Md.

DATE REC'D BY LOCAL REG.: Mar 28 1955
REGISTRAR'S SIGNATURE: Hamet Miller
24. FUNERAL DIRECTOR: John R. Byers ADDRESS: Westminster, Md.

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01472

1488 **CERTIFICATE OF DEATH** Reg. Dist. No. 7

1. PLACE OF DEATH:
COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
MARYLAND LENGTH OF STAY (in this place) 3yrs. 1mo.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City
STREET ADDRESS (If rural give location) 1002 Lyndhurst Street

3. NAME OF DECEASED: (Type or Print) (First) Catherine (Middle) [illegible] (Last) Koontz

4. DATE OF DEATH: (Month) 2 (Day) 15 (Year) 1955

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE MARRIED WIDOWED DIVORCED (Specify): [illegible]
8. DATE OF BIRTH 8-5-1870
9. AGE last birthday 84 yrs. IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Ireland
12. CITIZEN OF WHAT COUNTRY? Ireland

13. FATHER'S NAME: William Finn
14. MOTHER'S MAIDEN NAME: Honora Sullivan
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) ——— (If Yes, give war or dates of service) ———
16. SOCIAL SECURITY NO. ———
17. INFORMANT & ADDRESS. Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE 4.20.1	(A) Coronary occlusion	4 days
ANTECEDENT CAUSE (B)	DUE TO (B) Chronic myocarditis	10 yrs.
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (C) Generalized arteriosclerosis	12 yrs.

II SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Senile psychosis

19A. DATE OF OPERATION: ———
19B. MAJOR FINDINGS OF OPERATION ———
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, street, office bldg., etc. OF INJURY
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-7-, 19 52 to 2-15-, 19 55 that I last saw the deceased alive on 2-14-, 19 55, and that death occurred at 5:55 A.M, from the causes and on the date stated above.

SIGNATURE M. N. Mastin, M.D. ADDRESS M.D Springfield Hosp. Sykesville DATE SIGNED 2-15-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 2/18/55
NAME OF CEMETERY OR CREMATORY New Cathedral
LOCATION (City, town, or county) (State) Balto. 29. Md.

DATE REC'D BY LOCAL REGISTRAR 2-16-55
REGISTRAR'S SIGNATURE [illegible]
24. FUNERAL DIRECTOR Harry A. Luhrs
ADDRESS 4101 Edmondson Ave

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01474

1489 CERTIFICATE OF DEATH

Reg. Dist. No. 70

1. NAME OF DECEASED (Type or Print) Carroll County Mrs.Blanche B.Lawrence

2. DATE OF DEATH Feb.7,1955

3. PLACE OF DEATH: XXXXXXXXXX, Maryland Taneytown R.D.1

3a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) X OO

3c. Length of stay in Taneytown Rural 56 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Carroll
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Taneytown, Rural X
D. STREET ADDRESS (If rural, give location) /

5. SEX F
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH Feb.14,1898
9. AGE (In years last birthday) 56 (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house work
10B. KIND OF BUSINESS OR INDUSTRY own home
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Bernard J.Feeser
14. MOTHER'S MAIDEN NAME Barbara Fleagle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT Norman Lawrence ADDRESS Taneytown,Md.R#1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma: Rectum — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs
DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Metastasis
DUE TO
(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 8 1954 *to* Feb 7 1955 *that I last saw the deceased alive on* Feb 7, 1955 *and that death occurred at* — *m., from the causes and on the date stated above.*

23A. SIGNATURE M. D. J. H. Legg
23B. ADDRESS Union Bridge Md
23C. DATE SIGNED 2-7-55

24A. BURIAL, CREMATION, REMOVAL (Specify) burial
24B. DATE Feb.9,1955.
24C. NAME OF CEMETERY OR CREMATORY Reformed Church
24D. LOCATION (City, town, or county) (State) Taneytown, Md.

DATE RECEIVED BY LOCAL REGISTRAR Feb.8,1955
REGISTRAR'S SIGNATURE Ethel M Mehring Local
25. FUNERAL DIRECTOR C.O.FUSS & SON
ADDRESS Taneytown,Md.

VS. A15 — 10 - 53

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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CEIVED

11 1955

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01475

1490 **CERTIFICATE OF DEATH** Reg. Dist. No.

1. PLACE OF DEATH: Carroll COUNTY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (In this place) 19 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: [redacted] STATE M. D. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural give location) 2138 W. Fayette St.

3. NAME OF DECEASED: (Type or Print) (First) Bessie (Middle) WEBB (Last) Link

4. DATE OF DEATH: (Month) Feb. (Day) 5 (Year) 1955

5. SEX: F | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widowed | 8. DATE OF BIRTH. Nov. 5 - 1883 | 9. AGE last birthday 71 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife | 10B. KIND OF BUSINESS OR INDUSTRY: at home | 11. BIRTHPLACE (State or foreign country): Kent County Delaware | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: [illegible] Webb | 14. MOTHER'S MAIDEN NAME: [illegible]

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO. no | 17. INFORMANT & ADDRESS: Mr. J. Harold Link-2500 K St., N. W., Wash. D.C.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1 IMMEDIATE CAUSE (A) Coronary Occlusion ?

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Manic Depressive Psychosis

19A. DATE OF OPERATION: | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11 - 27, 1955 to 2 - 5, 1955, that I last saw the deceased alive on 2 - 4, 1955, and that death occurred at 5 a.M, from the causes and on the date stated above.

SIGNATURE Gerhard Sonnenfeld M.D. ADDRESS Springfield State Hospital Sykesville Md. DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 2/,/55 | NAME OF CEMETERY OR CREMATORY Lorraine Park | LOCATION (City, town, or county) (State) Woodlawn, Md.

DATE REC'D BY LOCAL REGISTRAR 2-7-55 | REGISTRAR'S SIGNATURE [illegible] | 24. FUNERAL DIRECTOR Wm. J. Pickard & Son ADDRESS Balto 17, Md.

VS. A15 — 10 - 53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01476

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1462

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
LENGTH OF STAY (In this place) 79 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 77 Penna Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
STREET ADDRESS (If rural, give location) 77 Penna. Ave.

3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last)	4. DATE OF DEATH: (Month) (Day) (Year)
WILLIAM FRANKLIN LONG	Feb. 16 1955

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
M	W	Widowed	June 28, 1875	79 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Plumber ret.	Westminster Hdw. Co.	Md.	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Abraham Long	Joanna Lantz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
No	214-01-1730	Mary K. Staub 77 Penna. Ave. Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH
331K Immediate cause	(a) Cerebral hemorrhage	5 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) DUE TO Arteriosclerosis	6 + yrs
	(c) DUE TO	

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 19 49, to Feb 16, 1955 that I last saw the deceased alive on Feb 14, 1955 and that death occurred at 4:50 A.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE)	ADDRESS	DATE SIGNED
Wilbur Teets MD	Westminster	2/17/55

23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	2-19-1955	Strider Cemetery	Westminster	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2-17-55	Hazel Miller	H. Bankard Son	Westminster, Md.

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01477

1491 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 2yr.3mo.17days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED.
STATE Maryland COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City (18)
STREET ADDRESS (If rural give location) 2018 St. Paul Street

3. NAME OF DECEASED: (Type or Print) (First) PEARL (Middle) ESTELLE (Last) MARFIELD

4. DATE OF DEATH (Month) (Day) (Year) February 21 1955

5. SEX Female | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Divorced | 8. DATE OF BIRTH: 2-27-82 | 9. AGE last birthday IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. 72 yrs

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles H. Marfield

14. MOTHER'S MAIDEN NAME: Emma Kinsey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) Unk. (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. Unk.

17. INFORMANT & ADDRESS. Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

002X
IMMEDIATE CAUSE (A) Pulmonary tuberculosis, far-advanced, with cavitation. — ?

ANTECEDENT CAUSE (B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE OR CONDITION CAUSING DEATH. CBS, with disturbance of growth, metabolism, or nutrition, with senile brain disease, with psychotic reaction. — Years

19A. DATE OF OPERATION: | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, street, office bldg., etc. OF INJURY | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-3- , 1955, to 2-21 , 1955, that I last saw the deceased alive on 2-20 , 1955, and that death occurred at 4:05AM, from the causes and on the date stated above.

SIGNATURE Walther H. Sonnenfeld M. D. | ADDRESS Springfield State Hospital | DATE SIGNED 2-21-55

23 BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 2-22-55 | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) 1900 East Pratt St. Balto.

DATE REC'D BY LOCAL REGISTRAR Feb. 22, 1955 | REGISTRAR'S SIGNATURE C. Harry Weis

24. FUNERAL DIRECTOR J. A. Metzler Sons | ADDRESS 1900 East Pratt St. Balto.

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
MAR 4 1955
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1492

01478

CERTIFICATE OF DEATH

Reg. Dist. No. 1114

1. PLACE OF DEATH:
COUNTY carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville
LENGTH OF STAY (in this place) 7 mos. 18 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Baltimore City
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
STREET ADDRESS (If rural give location) 268 S. Dallas Court

3. NAME OF DECEASED: (Type or Print) (First) EDMUND (Middle) JAMES (Last) MC NEILL

4. DATE OF DEATH: (Month) 2 (Day) 3 (Year) 1955

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married

8. DATE OF BIRTH: 5/9/79

9. AGE last birthday 75 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Steel worker

10B. KIND OF BUSINESS OR INDUSTRY: Steel

11. BIRTHPLACE (State or foreign country): Canada

12. CITIZEN OF WHAT COUNTRY? U

13. FATHER'S NAME: Patrick McNeill

14. MOTHER'S MAIDEN NAME: Susanne

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. Unk

17. INFORMANT & ADDRESS: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

177X
IMMEDIATE CAUSE (A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST
DUE TO (B) Cardiovascular disease — years

DUE TO (C) Cancer of prostate gland — 3 years

SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE OR CONDITION CAUSING DEATH: Chronic brain syndrome associated with cerebral arteriosclerosis, psychotic react. 8 mos.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/16, 1954, to 2/3, 1955, that I last saw the deceased alive on 2/3/, 1955, and that death occurred at 7:15 P.M., from the causes and on the date stated above.

SIGNATURE Arthur H. Stunnenfeldt, M.D. ADDRESS Sykesville, Md. DATE SIGNED 2/4/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF 2-7-55 — NAME OF CEMETERY OR CREMATORY Mt. Lebanon — LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REGISTRAR 2-7-1955 — REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR — ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01479

1493

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 9yr.4mo.7days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City
STREET ADDRESS (If rural give location) Unk-

3. NAME OF DECEASED: (Type or Print) (First) AGNES (Middle) CASANDRA (Last) McPARLIN

4. DATE OF DEATH: (Month) (Day) (Year) February 26 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 12-8-1869

9. AGE last birthday: 85 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10B. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Andrew McParlin

14. MOTHER'S MAIDEN NAME: Alida Roca

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No
(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. Unk-

17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

IMMEDIATE CAUSE (A) Myocardial infarct — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

ANTECEDENT CAUSE (B) Arteriosclerotic cardiovascular disease — Years

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Schizophrenia, paranoid type. — Many Years

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-23, 1955, to 2-26, 1955, that I last saw the deceased alive on 2-26, 1955, and that death occurred at 10:30PM, from the causes and on the date stated above.

SIGNATURE Walter A. Sommerfeldt M. D. ADDRESS Springfield State Hospital DATE SIGNED 2-28-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF 3-2-55

NAME OF CEMETERY OR CREMATORY Arlington National

LOCATION (City, town, or county) (State) Arlington, Va.

DATE REC'D BY LOCAL REGISTRAR Mar. 28, 1955

REGISTRAR'S SIGNATURE C. Finney Dean

24. FUNERAL DIRECTOR Wilbert H. Speight

ADDRESS Hyattsville, Md.

RECEIVED
MAR 4 1955
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1494 **CERTIFICATE OF DEATH** Reg. Dist. No. 01480

1. PLACE OF DEATH:
COUNTY CARROLL MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Rural - Sykesville
LENGTH OF STAY (in this place) 3Y 3M 26 D
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City
STREET ADDRESS (If rural give location) 621 Darley Avenue, Balto.

3. NAME OF DECEASED: (Type or Print) (First) TERESA (Middle) (Last) MUMBERT

4. DATE OF DEATH. (Month) 2 (Day) 7 (Year) 19 55

5. SEX: F | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married | 8. DATE OF BIRTH: 11/8/88 | 9. AGE last birthday 67 66 yrs | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Tormollan

14. MOTHER'S MAIDEN NAME: Louise A. Gronan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS. Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1 IMMEDIATE CAUSE (A) Cardio-vascular disease — INTERVAL BETWEEN ONSET AND DEATH: years

ANTECEDENT CAUSE (B) DUE TO (B) Arteriosclerosis — years

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Parkinson - Syndrome — 2 years +

SIGNIFICANT CONDITIONS CONTRIBUTING DEATH BUT NOT RELATED TO THE OR CONDITION CAUSING DEATH. Psychosis with cerebral arteriosclerosis — 5 years

19A. IF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/11, 1951, to 2/7, 1955 that I last saw the deceased alive on 2/6, 1955, and that death occurred at 9:30 A M, from the causes and on the date stated above.

SIGNATURE Edmund Lusthaus M. D. ADDRESS Sykesville, Maryland DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF Feb 10, 55 | NAME OF CEMETERY OR CREMATORY Immanuel Cem. | LOCATION (City, town, or county) (State) Balto Co

DATE REC'D BY LOCAL REGISTRAR 2-9-55 | REGISTRAR'S SIGNATURE [illegible] | 24. FUNERAL DIRECTOR Pallas Brennan | ADDRESS 6067 Hilf. Rd

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1495

01481

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 75

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
LENGTH OF STAY (In this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS RD #3

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE md COUNTY Carroll
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Westminster
STREET ADDRESS (If rural, give location) RD #3

3. NAME OF DECEASED: (Type or Print) (First) HORACE (Middle) DAVID FRANKLIN P. (Last) NULL

4. DATE OF DEATH (Month) Jan (Day) 1 (Year) 19 55

5. SEX: M | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single | 8. DATE OF BIRTH: 9/14/80 | 9. AGE last birthday: 74 yrs. | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Farmer | 10b. KIND OF BUSINESS OR INDUSTRY: own Farm | 11. BIRTHPLACE (State or foreign country): Carroll Co md | 12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: David J Null | 14. MOTHER'S MAIDEN NAME: Ann Wimert

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO.: none | 17. INFORMANT & ADDRESS: Milton A Fuerling Westminster Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Exposure to Cold. — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) Senility

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: | 19b. MAJOR FINDING OF OPERATION: | 20. AUTOPSY? Yes ☐ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY | 21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M. | 21e. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and find that death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE James J. Marsh M. D. — CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☑ — DATE SIGNED 2-4-55

23. BURIAL, CREMATION, REMOVAL (Specify): Buried | DATE THEREOF 2/7/55 | NAME OF CEMETERY OR CREMATORY Bachman Valley Cem | LOCATION (City, town, or county) (State) Carroll Co Md.

DATE REC'D BY LOCAL REG. Feb 4 55 | REGISTRAR'S SIGNATURE Mrs H R S Denner | 24. FUNERAL DIRECTOR ADDRESS R B Wisner Manchester Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

Special query form sent to Doctor regarding the "exposure" -- death was caused solely by effects of Exposure. 2/14/55 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01482

1496

Item 2, Film 177 2-17-55 et

CERTIFICATE OF DEATH

Reg. Dist. No. 7H

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 24 y.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: ✓ STATE M. D. COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville X
STREET ADDRESS (If rural give location) Springfield State Hosp.
No further information obtainable

3. NAME OF DECEASED: (Type or Print) (First) Estelle (Middle) H. (Last) Quinlan
4. DATE OF DEATH: (Month) 2 (Day) 4 (Year) 1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
F	W		11-2-1870	84 yrs.				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic	Home	Carroll County, M.D.	U.S.A.

13. FATHER'S NAME: Akers, Tobias
14. MOTHER'S MAIDEN NAME: Merryman, Ida

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. Unk
17. INFORMANT & ADDRESS: Hospital - Records

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
153X IMMEDIATE CAUSE	(A) Uremia	weeks
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (B) Metastatic involvement of genito-urinary tract	months
	DUE TO (C) Carcinoma of large intestine	8 years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	Schizophrenia, paranoid type	25 years

19A. DATE OF OPERATION:	19B MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21E INJURY OCCURRED While at work ☐ Not while at work ☐	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-10, 1930, to 2-4, 1955, that I last saw the deceased alive on 2-3, 1955, and that death occurred at 8:10 A.M, from the causes and on the date stated above.

SIGNATURE	ADDRESS	DATE SIGNED
Gertrud Sonnenfeldt M.D.	Springfield State Hospital Sykesville Md.	2/4/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2-7-55	New Cathedral	Baltimore Md.

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb 5, 1955	C. Henry Ulens	Wm Cook Inc.	1217 W. Fayette St. Balto 21

01483

1497

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 82-83

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X Rural--Sykesville
LENGTH OF STAY (In this place): Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 00

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural--Sykesville
STREET ADDRESS (If rural, give location): X /

3. NAME OF DECEASED (Type or Print): (First) LUCINDA (Middle) E. (Last) REAVER

4. DATE OF DEATH: (Month) FEB. (Day) 13, (Year) 1955

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed

8. DATE OF BIRTH: 1-15-1864

9. AGE last birthday: 91 yrs. If under 1 year: Months / Days / If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: John Wolbert

14. MOTHER'S MAIDEN NAME: Catherine ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If year, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: Mrs. Beulah Clark, Sykesville, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4 wks

Immediate cause (a) Valvular heart disease — Interval between onset and death: 2 yrs +

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 1, 1950, to Feb. 13, 1955 that I last saw the deceased alive on Jan 5, 1955, and that death occurred at 10: P m., from the causes and on the date stated above.

SIGNATURE (Degree or title): C Reese Wilkens, M.D — ADDRESS: Westminster — DATE SIGNED: 2/14/55

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — DATE: 2-16-1955 — NAME OF CEMETERY OR CREMATORY: Morgan Chapel — LOCATION (City, town, or county) (State): Carroll Co., Maryland

DATE RECD BY LOCAL REGISTRAR: Feb. 15 1955 — REGISTRAR'S SIGNATURE: Dy - Robert R. Hewitt

24. FUNERAL DIRECTOR — ADDRESS: C. M. Waltz, Winfield, Maryland

1498

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01484
Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 26

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Rural, Westminster
LENGTH OF STAY (In this place) 45 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS New Windsor Church

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Carroll
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Rural, Westminster RD #4
STREET ADDRESS (If rural, give location) Near Fosters Church

3. NAME OF DECEASED: (Type or Print) (First) GEORGE (Middle) L. (Last) REESE

4. DATE OF DEATH (Month) Feb (Day) 10 (Year) 19 55

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
M	W	Married	June 24 1886	68 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk	grain mill	Carroll Co. Md.	U.S.A.

13. FATHER'S NAME: John Reese

14. MOTHER'S MAIDEN NAME: Mary Cullison

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 212-01-8712

17. INFORMANT & ADDRESS: Mrs. George L. Reese Westminster, RD #4

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a)	Coronary Occlusion	5 minutes
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b)		
DUE TO		
(c)		

420.1

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE James J. Marsh M. D.

CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAM. ☒

DATE SIGNED 2/10/55

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY ~~OR CREMATORY~~	LOCATION (City, town, or county) (State)
Burial	Feb. 13-55	Fosters' Cemetery	Rural, Westminster, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb 12 1955	Harriet Miller	J. V. Myers Jr.	Westminster, Md.

VS. A15A - 5 - 53

PLEASE WRITE LEGIBLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
FEB
BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A11—10-53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1499

01485

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: ~~Springfield State Hospital~~
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 6 weeks
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Baltimore City
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
STREET ADDRESS (If rural give location) 3701-4 403 N. Streeper St.

3. NAME OF DECEASED (Type or Print): (First) Mary Anna (Middle) (Last) Ritter

4. DATE OF DEATH: (Month) Feb (Day) 17 (Year) 1955

5. SEX: F

6. COLOR OR RACE: Wh

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Mar

8. DATE OF BIRTH: Jan 10, 1894

9. AGE last birthday: 61 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: XXX

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Joseph Bishop

14. MOTHER'S MAIDEN NAME: Elizabeth Senft

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO: XXX

17. INFORMANT & ADDRESS: Hospital Records.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X
IMMEDIATE CAUSE (A) Cerebro-vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs

ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST
DUE TO (B) Essential hypertension — years

DUE TO (C)

II SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Involutional psychotic reaction — 2½ years

19A. DATE OF OPERATION: XXX

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY occur?

22. I hereby certify that I attended the deceased from Feb 16, 1955, to Feb 17, 1955, that I last saw the deceased alive on Feb 16, 1955, and that death occurred at 12:40A M, from the causes and on the date stated above.

SIGNATURE Walter H. Rommelfell M.D. ADDRESS Springfield State Hosp. DATE SIGNED 2/17/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF Feb. 21, 1955 — NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery — LOCATION (City, town, or county) (State) Baltimore, Maryland

DATE REC'D BY LOCAL REGISTRAR 2/21/55 — REGISTRAR'S SIGNATURE U. W. Hedrick

24. FUNERAL DIRECTOR Wm. J. Tickner & Sons Inc. — ADDRESS Baltimore Md.

1500

01486

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 70

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Taneytown
LENGTH OF STAY (in this place) 39
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Taneytown
STREET ADDRESS (If rural, give location) 1

3. NAME OF DECEASED: (First) Miss Mae (Middle) M (Last) Sanders

4. DATE OF DEATH (Month) Feb (Day) 16 (Year) 19 55

5. SEX: F

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: June 8, 1889

9. AGE last birthday: 65 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): operator

10b. KIND OF BUSINESS OR INDUSTRY: Telephone

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles E. Sanders

14. MOTHER'S MAIDEN NAME: Annie E. Myers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 216-10-6072

17. INFORMANT & ADDRESS: Guy S. Sanders, Gettysburg, Pa. R#5

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Months

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Lea & Breast

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc.. INJURY

21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE James T Marsh M. D.

CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAM. ☐

DATE SIGNED 2/16/55

23. BURIAL, CREMATION, REMOVAL (Specify): burial

DATE THEREOF Feb. 19, 1955

NAME OF CEMETERY OR CREMATORY St. Joseph's

LOCATION (City, town, or county) Bonneville, Pa. (State)

DATE REC'D BY LOCAL REG. Feb. 17, 1955

REGISTRAR'S SIGNATURE Ethel M. Mahrle

24. FUNERAL DIRECTOR C.O. FUSS & SON

ADDRESS Taneytown, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01487

1501

CERTIFICATE OF DEATH

Reg. Dist. No. . . .

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Carrol — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Sykesville
LENGTH OF STAY (in this place) —
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md — COUNTY ———
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City
STREET ADDRESS (If rural give location) 415 N. Luzerne Ave

3. NAME OF DECEASED: (Type or Print) (First) Frederica (Reta) (Middle) (Last) Seidel

4. DATE OF DEATH: (Month) Feb 13 (Day) (Year) 1955

5. SEX: fem.

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): wid.

8. DATE OF BIRTH: 7-12-85

9. AGE last birthday: 69 yrs. IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife?

10B. KIND OF BUSINESS OR INDUSTRY: at home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Gustave Schnaufer

14. MOTHER'S MAIDEN NAME: Barbara Schaefer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) ——— (If Yes, give war or dates of service) ———

16. SOCIAL SECURITY NO. ?

17. INFORMANT & ADDRESS. Records of Springfield Stat. Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4.0.0

IMMEDIATE CAUSE (A) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSE (B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (B) Arteriosclerotic heart disease more than 10 months

(C) DUE TO

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH Senile psychosis more than 10 months

19A. DATE OF OPERATION ———

19B. MAJOR FINDINGS OF OPERATION ———

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY ———

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) ———

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. ———

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR? ———

22. I hereby certify that I attended the deceased from 4-9- , 1954, to 2-13 - , 1955, that I last saw the deceased alive on 2 - 13 -, 1955, and that death occurred at 6:40 PM, from the causes and on the date stated above.

SIGNATURE Martin Gross, M.D. — ADDRESS — DATE SIGNED

Martin Gross, M.D. for Springfield St. Hosp., Sykesville, Md. 2-13-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal — DATE THEREOF 2/16/55 — NAME OF CEMETERY OR CREMATORY Fairmount Cem. — LOCATION (City, town, or county) (State) Newark, N. J.

DATE REC'D BY LOCAL REGISTRAR 2-15-55 — REGISTRAR'S SIGNATURE [signature] — 24. FUNERAL DIRECTOR ADDRESS Wm. J. Fickner & Sons-Balto.17, Md.

1502

01488

Item 2: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Sykesville
LENGTH OF STAY (In this place) 1 yr. 5 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Westminster
STREET ADDRESS (If rural, give location) RFD #4

3. NAME OF DECEASED: (Type or Print) (First) ANNIE (Middle) Leona (Last) SNYDER

4. DATE OF DEATH (Month) 2/ (Day) 21 (Year) 19 55

5. SEX: Female

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed

8. DATE OF BIRTH: 7/26/1862

9. AGE Last birthday: 92 yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ---- Samuel Hann

14. MOTHER'S MAIDEN NAME: ---- Matilda Utz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) U.K. -
(If Yes, give war or dates of service) -

16. SOCIAL SECURITY NO.: Unk -

17. INFORMANT & ADDRESS: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:
Immediate cause (a) 902.7 DUE TO Pulmonary embolism — Interval Between Onset and Death: unknown
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic Brain Syndrome associated with senile brain disease, with psychotic react.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Hospital

21c. (City or town) Sykesville, (County) Carrol l (State) Md.

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M

21e. INJURY OCCURRED While at work ☐ Not while at work ☒

21f. HOW DID INJURY OCCUR? Patient fell from bed

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE James J. Thorek M. D.

CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAM. ☐

DATE SIGNED 2/21/55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF 2-24-55

NAME OF CEMETERY OR CREMATORY Fustus cemtery

LOCATION (City, town, or county) (State) carroll co md

DATE REC'D BY LOCAL REG. Feb 24 1955

REGISTRAR'S SIGNATURE C. Avery Ward

24. FUNERAL DIRECTOR Edw. C. Tipton ADDRESS Hampstead Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

RECEIVED
MAR 4 1955
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01489

1503

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Sykesville
LENGTH OF STAY (in this place) 8 mo.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY ——
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City 3V 1-4
STREET ADDRESS (If rural give location) 3420 Ash St.

3. NAME OF DECEASED: (Type or Print) (First) Horace (Middle) Wesley (Last) Souder

4. DATE OF DEATH: (Month) Feb (Day) 22 (Year) 1955

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): wid.

8. DATE OF BIRTH: 8-11-72

9. AGE last birthday IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.: 82 yrs.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): gardener

10B. KIND OF BUSINESS OR INDUSTRY: ——

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jacob Souder

14. MOTHER'S MAIDEN NAME: Mary Liz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) ——

16. SOCIAL SECURITY NO. ——

17. INFORMANT & ADDRESS: Records of Springfield State Hosp.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X
IMMEDIATE CAUSE (A) Cerebro-vascular accident(hemmorrhage) — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs

ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
DUE TO (B) Arteriosclerosis — more than 2 yrs

DUE TO (C)

II SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE OR CONDITION CAUSING DEATH Psychosis with cerebr. arteriosc. more than 2 yrs

19A. OPERATION: ——
19B. MAJOR FINDINGS OF OPERATION ——
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.) ——
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) ——

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. ——
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW D D INJURY OCCUR? ——

22. I hereby certify that I attended the deceased from Aug. 15, 1954 to Feb. 22, 1955, that I last saw the deceased alive on Feb, 22, 1955, and that death occurred at 10:00 PM, from the causes and on the date stated above.

SIGNATURE Martin Gross, M.D. Martin Gross M.D. — ADDRESS M.D. Sykesville, Md — DATE SIGNED Feb. 22, 1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF 2-25-55 — NAME OF CEMETERY OR CREMATORY Emmanuel — LOCATION (City, town, or county) (State) Westminster, Md.

DATE REC'D BY LOCAL REGISTRAR Feb. 23, 1955 — REGISTRAR'S SIGNATURE J. Harvey Zile

24. FUNERAL DIRECTOR Wilbur Hamner — ADDRESS Westminster, Md.

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
MAR 4 1955
BUREAU V. S.

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01490

1501 CERTIFICATE OF DEATH Reg. Dist. No.

1. PLACE OF DEATH: COUNTY Carroll MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Sykesville; LENGTH OF STAY (in this place) 22yrs. 7days; HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City; STREET ADDRESS (If rural give location) Unknown

3. NAME OF DECEASED: (Type or Print) (First) Sophie (Middle) -- Eva (Last) Sprunk

4. DATE OF DEATH: (Month) 2 (Day) 9 (Year) 1955

5. SEX Female | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married | 8. DATE OF BIRTH: 11-24-1889 | 9. AGE last birthday: 65 yrs. | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Char woman | 10B. KIND OF BUSINESS OR INDUSTRY: --- | 11. BIRTHPLACE (State or country): Germany | 12. CITIZEN OF WHAT COUNTRY? Germany

13. FATHER'S NAME: Alexander Grinewetzky | 14. MOTHER'S MAIDEN NAME: Nelda Myers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No | (If Yes, give war or dates of service) ---- | 16. SOCIAL SECURITY NO. ---- | 17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4-8-X

IMMEDIATE CAUSE (A) DUE TO: Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B) DUE TO: Influenza — Puls —

(C) Epilepsy — 50 yrs

II SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: ---- | 19B. MAJOR FINDINGS OF OPERATION ---- | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY ---- | 21C. WHERE DID INJURY OCCUR? (City or town) ---- (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) ---- M. | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR? ----

22. I hereby certify that I attended the deceased from 2-11-, 1941 to 2-9-, 1955, that I last saw the deceased alive on 2-8-, 1955 and that death occurred at 3:00 AM, from the causes and on the date stated above.

SIGNATURE M. N. Martin, M.D. ADDRESS Springfield State Hosp. Sykesville, Md. DATE SIGNED 2-9-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 2/11/55 | NAME OF CEMETERY OR CREMATORY Loudon Park Cem. | LOCATION (City, town, or county) (State) Baltimore, Md.

DATE REC'D BY LOCAL REGISTRAR 2/10/55 | REGISTRAR'S SIGNATURE A. V. Hedrick M.D. | 24. FUNERAL DIRECTOR Wm. J. Tickner & Sons | ADDRESS Balto 17 Md

1595

01491

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 7-6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Carroll — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Finksburg — LENGTH OF STAY (in this place) 3 mos
HOSPITAL OR INSTITUTION OR STREET ADDRESS Gunnis Nurs. Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Finksburg
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) HARRY (Middle) A (Last) STEM
4. DATE OF DEATH: (Month) Feb (Day) 1 (Year) 1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
M	W	Widowed	Nov 19 1875	79 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farmer
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Charles W Stem
14. MOTHER'S MAIDEN NAME: Josephine Hartley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 179-20-5859
17. INFORMANT AND ADDRESS: Mrs Raymond Koppenhaffer Hampstead Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chronic Myocarditis

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension Cardio-Vascular Renal (c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) —
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY —
(CITY OR TOWN) (COUNTY) (STATE) —

TIME OF INJURY (Month) (Day) (Year) (Hour) m. —
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from July 1, 1950, to February 1, 1955, that I last saw the deceased alive on Jan 31, 1955, and that death occurred at 3:20 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Joseph E Burke MD Hampstead Md 2-1-55

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Feb 3/55	St James	Carroll Co Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2-3-1955	Harriet Miller	Edw R Upton	Hampstead Md

RECEIVED
8 7 1955
BUREAU V

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01492

Item 1, Film 11.7 2-21-55 et

CERTIFICATE OF DEATH

1506 Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
LENGTH OF STAY (in this place) 2month23days
HOSPITAL OR INSTITUTION OR STREET ADDRESS SPRINGFIELD STATE HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) CATHERINE (Middle) (Last) STOLSKI

4. DATE OF DEATH (Month) (Day) (Year) February 15 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 1883

9. AGE last birthday: 71 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Russia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Pulmonary Tuberculosis DUE TO — INTERVAL BETWEEN ONSET AND DEATH: years

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (B) DUE TO

(C)

II SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE OR CONDITION CAUSING DEATH. Mental deficiency, plus pulmonary tuberculosis. 10yrs.

19A. OPERATION. 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-22, 1954, to 2-15, 1955, that I last saw the deceased alive on 2-15, 1955, and that death occurred at 7:30 P.M. from the causes and on the date stated above.

SIGNATURE Walter H. Sonnendeldt M.D. ADDRESS Springfield State Hospital DATE SIGNED 2/17/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial DATE THEREOF 2-17-55 NAME OF CEMETERY OR CREMATORY Sacred Heart LOCATION (City, town, or county) German Hill Rd (State)

DATE REC'D BY LOCAL REGISTRAR 2-17-55 REGISTRAR'S SIGNATURE [illegible]

24. FUNERAL DIRECTOR J. J. Fahey & Son ADDRESS 1316 Light St

VS. A15—10-53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1507

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01493

CERTIFICATE OF DEATH

Reg. Dist. No. 16

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Carrollton
LENGTH OF STAY (in this place): life
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 00

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Carrollton
STREET ADDRESS (If rural, give location): /

3. NAME OF DECEASED (Type or Print): (First) Gust (Middle) (Last) Taylor

4. DATE OF DEATH: (Month) Feb. (Day) 23 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED OR DIVORCED (Specify): Single

8. DATE OF BIRTH: Apr. 19, 1867

9. AGE last birthday: 87 yrs. — If under 1 year: Months — Days — If under 24 hrs.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): day laborer

10b. KIND OF BUSINESS OR INDUSTRY: farms

11. BIRTHPLACE (State or foreign country): Carrollton, Maryland

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: John H. Taylor

14. MOTHER'S MAIDEN NAME: Margarette Magee

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: ---------

17. INFORMANT AND ADDRESS: J. Carroll Taylor Carrollton, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset and Death: 3 days

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Cardio vascular disease — 10 years

(c) Senility — 10 years

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: none

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): no

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): none m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb., 19[illegible], to Feb. 23, 1955, that I last saw the deceased alive on Feb. 23, 1955, and that death occurred at 4 P. m., from the causes and on the date stated above.

SIGNATURE: J. Billingslea (Degree or title) M. D. ADDRESS: Westminster, Md. DATE SIGNED: 2-24-55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Feb. 26, 1955 — NAME OF CEMETERY OR CREMATORY: Carrollton Church of God — LOCATION (City, town, or county) (State): Carrollton Md.

DATE REC'D BY LOCAL REG.: 2-25-55 — REGISTRAR'S SIGNATURE: Hazel Miller

24. FUNERAL DIRECTOR: John R. Byers — ADDRESS: Westminster, Md.

1955

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01494

1508

CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural-Sykesville
LENGTH OF STAY (in this place) since 6/2/51
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY ---
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City 8 W. 1 L
STREET ADDRESS (If rural give location) 606 E. Baltimore Street

3. NAME OF DECEASED: (Type or Print) (First) William (Middle) Frederick (Last) WERNER

4. DATE OF DEATH (Month) February (Day) 4 (Year) 1955

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: July 20, 1878

9. AGE last birthday: 76 yrs. IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS. Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Jeweler

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Otto Herman Werner

14. MOTHER'S MAIDEN NAME: Wilhelmia Stalfort

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) unknown (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. unknown

17. INFORMANT & ADDRESS: Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

491X IMMEDIATE CAUSE (A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 7 days

ANTECEDENT CAUSE (B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (B) DUE TO

(C)

II SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Senile psychosis, simple deterio - 5 years

19A. DATE OF OPERATION.

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 2, 1951, to Feb. 4, 1955, that I last saw the deceased alive on Feb. 4, 1955, and that death occurred at 1 p. M, from the causes and on the date stated above.

SIGNATURE Florian Nadolski M.D ADDRESS Sykesville Md DATE SIGNED Febr. 4 1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | DATE THEREOF 2-7-1955 | NAME OF CEMETERY OR CREMATORY GREENMOUNT | LOCATION (City, town, or county) BALTO. (State) MD

DATE REC'D BY LOCAL REGISTRAR 2-7-55 | REGISTRAR'S SIGNATURE A. W. Hedges | 24. FUNERAL DIRECTOR H. W. JENKINS & SONS CO. | ADDRESS 4905 YORK RD.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01495

1607

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Sykesville
LENGTH OF STAY (in this place) 32yr. 4mo. 26da.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 SPRINGFIELD STATE HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural give location) 1215 W. Mulberry Street ✓

3. NAME OF DECEASED: (Type or Print) (First) PHOEBE (Middle) N. (Last) WISCHMEYER

4. DATE OF DEATH. (Month) February (Day) 11 (Year) 1955

5. SEX. Female

6. COLOR OR RACE. White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH. June 6, 1895

9. AGE last birthday 59 yrs | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). Housework

10B. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Wrightson

14. MOTHER'S MAIDEN NAME: Nanna Porter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT & ADDRESS. Hospital records.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE 17 X

(A) Carcinoma of breast — INTERVAL BETWEEN ONSET AND DEATH: one years+

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST

DUE TO (B) with metastasis to pleura, mediastinum and

DUE TO (C)

R SIGNIFICANT CONDITIONS CONTRIBUTING DEATH BUT NOT RELATED TO THE OR CONDITION CAUSING DEATH. Schizophrenia, paranoid type 32 yr.

19A. DATE OF OPERATION. 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22 I hereby certify that I attended the deceased from 2-4- , 1955, to 2-11 , 1955, that I last saw the deceased alive on 2-11 , 1955. , and that death occurred at 8:35AM, from the causes and on the date stated above.

SIGNATURE W. H. Lowenfeld M. D. ADDRESS Springfield State Hospital DATE SIGNED 2/11/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 2/14/55 | NAME OF CEMETERY OR CREMATORY Lorraine Cem. | LOCATION (City, town, or county) Woodlawn, Md. (State)

DATE REC'D BY LOCAL REGISTRAR FEB 14 1955 | REGISTRAR'S SIGNATURE Curtis Williams, M.D. Nancy C. Williams | 24. FUNERAL DIRECTOR Wm. J. Pickney & Sons | ADDRESS Baltimore 17 Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1510 CERTIFICATE OF DEATH

Reg. Dist. No. 01496

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Rural - Sykesville, Md.
LENGTH OF STAY (in this place) 5Y 3M 17 D
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 3 V 0 1 - 4
STREET ADDRESS (If rural give location) 3314 Beech Avenue, Baltimore-11

3. NAME OF DECEASED: (Type or Print) (First) WILLIAM (Middle) McPHERSON (Last) WOOD

4. DATE OF DEATH: (Month) 2/ (Day) 15 (Year) 1955

5. SEX: Male | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Div. | 8. DATE OF BIRTH: 12/13/92 | 9. AGE last birthday: 62 yrs. | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plasterer

10B. KIND OF BUSINESS OR INDUSTRY: Self

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William S. Wood

14. MOTHER'S MAIDEN NAME: Mary E. Egler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) — (If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO. 217-09-3120

17. INFORMANT & ADDRESS: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

1487 IMMEDIATE CAUSE (A) Malignant neoplasm of pharynx — INTERVAL BETWEEN ONSET AND DEATH: 2 years

ANTECEDENT CAUSE (B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE OR CONDITION CAUSING DEATH Chronic Brain Syndrome associated with alcoholism, with psychotic reaction — Years

19A. DATE OF OPERATION: | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street or bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/18, 19 54 to 2/15, 19 55 that I last saw the deceased alive on 2/15/, 1955, and that death occurred at 12:25 PM, from the causes and on the date stated above.

SIGNATURE Walter H. Sonnenfeldt M.D. ADDRESS Sykesville, Maryland DATE SIGNED 2/15/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 2/18/55 | NAME OF CEMETERY OR CREMATORY Woodlawn | LOCATION (City, town, or county) (State) Woodlawn Md.

DATE REC'D BY LOCAL REGISTRAR 2-16-55 | REGISTRAR'S SIGNATURE [illegible] | 24. FUNERAL DIRECTOR Paul E. Lehmann | ADDRESS 816-47 Chestnut

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01497

1511. CERTIFICATE OF DEATH Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 43 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY ---
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3 W 01-4
STREET ADDRESS (If rural give location) 417 S. Paulings ave. unknown

3. NAME OF DECEASED: (Type or Print) (First) Catherine (Middle) --- (Last) Young
4. DATE OF DEATH: (Month) Feb. (Day) 6 (Year) 1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
fem.	white	married	1878 ?	77 ? yrs.				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
house work	Home	Baltimore City	U.S.A.

13. FATHER'S NAME: George ~~Makler~~ MAULER
14. MOTHER'S MAIDEN NAME: Lizzie Wolfe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No	---	Unk	Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1
IMMEDIATE CAUSE (A) Coronary occlusion — minutes
DUE TO
ANTECEDENT CAUSE (B) Hypertensive heart disease — more than 20 years
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Cystic goiter — more than 20 years

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☒ NO ☐
---	---	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
	---	---

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While at work ☐ Not while at work ☐	21F. HOW DID INJURY OCCUR?
--- M.		---

22. I hereby certify that I attended the deceased from June 13, 1912, to Feb. 6, 1955, that I last saw the deceased alive on Feb. 6, 1955, and that death occurred at 7:45 P.M., from the causes and on the date stated above.

SIGNATURE	ADDRESS	DATE SIGNED
Gertrud Sonnenfeld M.D. M. D.	Springfield State Hospital Sykesville Md.	Feb. 6, 1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2-9-55	Mt Carmel	Baltimore, Md.

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 7, 1955	C. Harry Weer	H. Hawkins Son - Mother Hawkins Balto.	

VS. A15—10-53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 9 1955
BUREAU V. S.

1512

01498

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

Item 21a film 9/19 3/3/55 ams

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville
LENGTH OF STAY (in this place) 20yr10mo20days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Frederick
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Frederick (Rural) 10K-2
STREET ADDRESS (If rural, give location) Route # 2

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
IESTER	NICODEMUS	ZIMMERMAN	February 16 1955

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Single	1-17-1892	63 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Farm Laborer	Agriculture	Maryland	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Benjamin F. Zimmerman	Minnie Roelkey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
No	None	Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: — INTERVAL BETWEEN ONSET AND DEATH

308.1
Immediate cause (a) Bronchopneumonia (Terminal) — 18 to 24hrs.
DUE TO
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
(b) Organic brain pathology to be determined. — 12 hours
DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Epileptic psychosis — Years

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Hospital	21c. (City or town) (County) (State)
		Sykesville Carroll Maryland

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work ☐ Not while at work ☒	21f. HOW DID INJURY OCCUR?
1 29 55 2:05 a.m.		Slipped while running, fell to floor

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE James L. Marsh M. D. — CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☐ — DATE SIGNED 2/16/55

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Feb.19,1955	Mount Olivet Cemetery	Frederick, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
Feb. 18, 1955	C. Henry Gilson	M. R. Etchison & Son, Frederick, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15A - 5 - 53

RECEIVED
FEB 21 1955
BUREAU V. S.